

Department of Health and Human Services  
Public Health Service

REPORT OF DENTAL EXAMINATION OF APPLICANTS TO THE  
COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE

NAME (Last, First, Middle) (Please type or print)	SOCIAL SECURITY NUMBER
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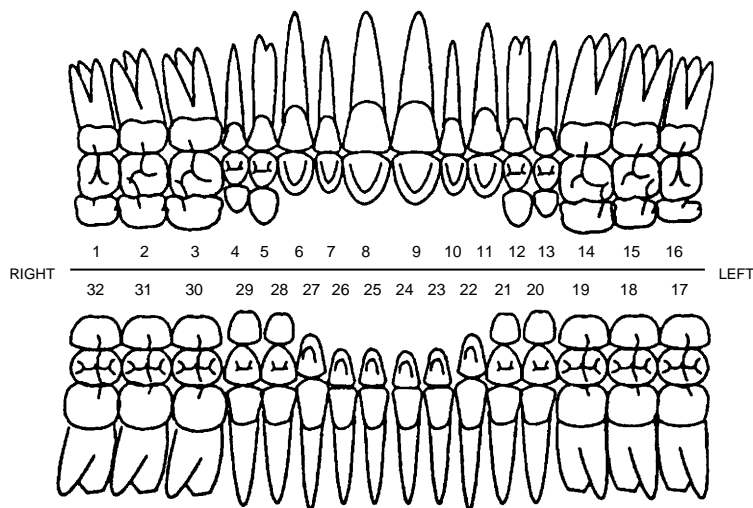
INSTRUCTIONS TO APPLICANT

Present this form to your examining dentist for completion. Failure by you or your examiner to comply completely will delay medical clearance, which is required prior to call to active duty. You may be able to obtain a dental examination at dental examination sections of military medical facilities. **If done privately, it must be done at your own expense.**

INSTRUCTIONS TO EXAMINING DENTIST

A complete examination is required in order that *all* questions listed below can be completed. If there are a number of "Yes" responses to questions listed below, or if otherwise clinically indicated, bitewing and panoramic (or diagnostic quality full mouth) radiographs should be performed. If examinee has a questionable occlusal relationship, forward diagnostic casts to the address at the end of this form.

- (1) Indicate on the chart below restorable teeth with an "R," non-restorable teeth with an "N," missing teeth with an "X," teeth replaced by a fixed or removable prosthetics by a "continuous line," and any other defects or abnormalities. Do not chart restorations.



- (2) GENERAL ("X" Yes or No for each question)

Yes	No	
		a. DENTAL CARIES (Indicate on chart, do not chart incipienties)
		b. MISSING TEETH, OTHER THAN THIRD MOLARS (Indicate on chart by marking "X" through the roots)
		c. NON-RESTORABLE TEETH (Indicate on chart by marking "N" through tooth)
		d. UNERUPTED TEETH (Draw circle around the tooth on the chart and indicate position by an arrow)
		e. DEVELOPMENTAL DISTURBANCES IN TEETH (Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)
		f. STAINED TEETH (Intrinsic) (unsightly)

- (3) HISTORY OR ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY

("X" Yes or No for each question. If additional space is needed use "REMARKS" section)

Yes	No	
		a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS (If so, describe)
		b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES (Describe)
		c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. (Describe)
		d. HISTORY OF CLEFT LIP
		e. HISTORY OF CLEFT PALATE
		(1) If yes, is there an oro-nasal or oro-antral fistula present?
		f. HISTORY OF TMJ DISEASE OR PAIN (Describe)

(Continued on reverse)

(4) OCCLUSAL RELATIONSHIP ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)

Yes	No	
		a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.
		b. ANTERIOR OVERBITE IN EXCESS OF 4mm.
		c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4 mm.
		d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE
		e. ANTERIOR CROSSBITE (Describe)
		f. MANDIBULAR PROGNATHISM
		g. POSTERIOR OPEN BITE (Bilateral involving more than one tooth)
		h. POSTERIOR CROSSBITE (Entire quadrant)
		i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
		J. MULTIPLE CONGENITALLY MISSING TEETH

(5) ORTHODONTICS ("X" Yes or No for each question)

Yes	No	
		a. PAST HISTORY OF ORTHODONTIC TREATMENT (If "Yes," date completed: _____)
		b. WAS INDICATION FOR ORTHODONTIC TREATMENT STRICTLY COSMETIC? (If functional corrections were made, please describe)
		c. WAS THERE EVER OR IS THERE NOW, ANY INDICATION OF POST TREATMENT ADVERSE SEQUELAE? (If "Yes," please explain)
		d. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (Specify fixed or removable)
		e. WEARING RETAINER APPLIANCES

(6) PROSTHODONTICS ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)

Yes	No	
		a. MISSING TEETH (Prosthesis required) (Describe)
		b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS (Describe)
		c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?

(7) PERIODONTAL STATUS ("X" Yes or No for each question)

Yes	No	
		a. MODERATE TO HEAVY CALCULUS (Supra and/or sub-gingival)
		b. GINGIVITIS (Generalized)
		c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS
		d. LOCAL OR GENERALIZED PERIODONTITIS (With associated bone loss)
		e. JUVENILE PERIODONTITIS
		f. PERIOPORONITIS

(8) RESULTS OF RADIOGRAPHIC EXAMINATION, IF PERFORMED ("X" Yes or No for each question)

(If additional space is needed, use "REMARKS" section)

Yes	No	
		a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA (Describe)
		b. IMPACTED TEETH WITH PATHOLOGY (Describe)
		c. IMPACTED TEETH WITH OTHER THAN THIRD MOLARS (Describe)
		d. OTHER RADIOGRAPHIC ABNORMALITIES (Describe)

(9) OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED ("X" Yes or No)

Yes	No

(10) REMARKS (Indicate item of reference) (Use additional sheet if necessary)

NAME AND ADDRESS OF EXAMINING DENTIST (Please type or print)	SIGNATURE OF DENTIST	DATE

FORWARD COMPLETED FORM AND ANY ATTACHMENTS TO: Division of Commissioned Personnel  
Attn: Medical Branch  
5600 Fishers Lane, Room 4C-14  
Rockville, MD 20857-0001